

ImpAct

- sharing experience
- defining good practice
- improving service delivery
- supporting learning in the NHS

July 2000 Volume 2 Issue 4

REFLECTIONS

'Time for reflection' is an important component of learning. We all need time to think about what and how we are doing. *ImpAct* thought that it was time that to step back and examine the messages from the case studies we've covered so far. What have we learnt? What have our readers made of *ImpAct* so far?

First we've pulled together the *ImpAct* bottom lines we attributed to the case studies and sought to draw general lessons from them. What do they mean for individuals and organisations in the NHS? It is interesting that they concentrate on working with patients, working with the people who make the NHS work, and working with systems to make their job easier, or possible. Most people in the NHS have the ability to make the impossible seem routine. This is timely given the imminent publication of the Government's plan for the NHS. A realistic approach to implementation will be a critical factor for success.

Second, we've reported on our initial look at how well the case studies have been received, who has expressed an interest and what's happened. 'Are we making an impact?' We have talked to a sample of people featured in *ImpAct* and those who made enquiries for further information. The results are encouraging. Our efforts seem to be having the desired effect: you are getting in touch with those we feature in the case studies and the information provided is helping to speed up local development work. Our thanks to all those who helped us with our enquiries.

We have two case studies in this issue. One describes a team approach to the management of pain: work which those involved wanted to share with colleagues across the NHS. The second describes better ways to breaking bad news to patients: relevant in many settings across the NHS: work at a unit featured in the SDP database. There is also progress to report on the new SDO research programme.

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The views expressed in ImpAct are those of the authors, and are not necessarily those of the NHSE

INTERNET INNOVATIONS

ImpAct users want more use of the Internet. In response *ImpAct* and *Bandolier* are working to provide a nascent one-stop-shop for information useful to individuals and organisations trying to improve health service delivery.

Part of this will involve trying to make tools or aids created by people involved in *ImpAct* stories available in html or pdf formats on the *ImpAct* website. This is an aim, and *ImpAct* will try to do this prospectively, and also will examine whether we can do it for stories already featured.

Extended site

The first initiative is already completed. As part of the re-development of the *Bandolier/ImpAct* site, there is a new topic area accessible off the *Bandolier* home page called "Management". In it we have collected all the *ImpAct* material, plus *ImpAct* stories for which we had no room in paper, plus stories from *Bandolier* relevant to improved health service delivery. Right now there are about 170 stories available in this section, and any story can be accessed with only three clicks from the *Bandolier* home page.

Literature summaries

In addition, *ImpAct* and *Bandolier* have been collecting published papers that might impact on improved health service delivery. Over time these will be summarised and added to the management site. Papers about management, or change, or health care improvement are not always easy to find. *ImpAct* would be grateful for suggestions from readers about literature to abstract.

Patience

Please be patient, though. This activity has little more than modest funding, and the whole *Bandolier/ImpAct* site is without any meaningful resource other than the time and goodwill of a few people. That doesn't mean it is without thought. Users of the site should be able to download quickly because its design deliberately allows access to any page within 10 seconds over the slowest modem. Any longer, and it's not our fault.

Please note the new *Bandolier/ImpAct* Internet address is www.ebandolier.com.

Electronic *ImpAct* on www.jr2.ox.ac.uk/Bandolier/IMPissue.html

ARE WE MAKING AN IMPACT?

The main messages from an initial evaluation of ImpAct

ImpAct's success depends on whether it can make a real contribution to sharing experiences across the NHS. Evaluation is therefore important. Apart from helping improve *ImpAct* we are looking to extend funding beyond spring 2001. We could evaluate *ImpAct* from several different perspectives, that of our regular readers, or that of those who should read us but don't! We decided to start with the reactions to the case studies featured in the first four issues of *ImpAct*. Two key questions were:

- ◆ How many people sought more information?
- ◆ Were they able to use the information to improve their own services?

Enquiries about case studies

People involved with 11 of the stories featured in the four issues helped us in our evaluation by keeping an informal log of contacts. Some had few enquiries (6 or 7), and these generally involved specialist activities. Those with broader interest had well over 30 enquiries. In total about 300 enquiries were received, an average of about 25. A good start.

Enquiries came from all disciplines. Several separate enquiries came from different people in the same Trust: could this suggest that some organisations are more successful in encouraging staff to seek out of ideas from elsewhere? As we'd expect most were from the UK but several were from further afield. It's good to know that the initiatives are relevant to readers in New Zealand, Australia and Japan. This prompted a question in our minds about whether readers outside the UK have completed work that is relevant to the UK or internationally? If so, we'd like to hear from you.

Those featured in the case studies were pleased with the level of interest. It helped to reinforce local commitment to the work they were doing, because it both raised its profile and demonstrated its importance. Several commented that

the level of interest was higher than following their articles in professional journals. It's good to know that *ImpAct* reaches the places other publications don't.

Why enquire?

We've also been in touch with a sample of people who contacted the 'case studies'. Their enquiries were on the whole prompted by the need for action locally and a desire to learn from the experience of others. They had the issue on their agenda, even though it might be a long way down. Typical comments were:

"We'd been thinking about idea of therapy assistants and were keen to hear about how it worked".

"We'd been trying to set up a similar scheme and were interested to know how they had overcome funding questions".

All found the additional information helpful. After the first couple of issues we started to warn people to expect a lot of enquires and have additional information available. The additional information seems to have helped build people's confidence to speed up their own local developments:

"It helped to persuade people locally that the change was possible because it had been proven elsewhere"

We've had similar informal comments from readers who have found the information provided in *ImpAct* gave them confidence to tackle difficult challenges.

What next?

It's good to talk to those involved in successful initiatives, and write about them. But that pleasure would be negated if no one else was interested. *ImpAct* is delighted to learn that its efforts are effective, that people are learning from one another and that local developments have been speeded up. Several people have suggested ways that we could improve *ImpAct*. These include more use of the Internet site and ensuring that the paper version gets to the 'right' people in NHS Trusts and Primary Care Groups. We'll be looking at these as part of our discussions to develop *ImpAct*.

SDO PROGRAMME

Evidence is very important to *ImpAct* so it is good news that work progresses with a new research programme looking the organisation of services: the *NHS Service Delivery and Organisation (SDO) Research & Development programme*. It will promote the use of research evidence about how the organisation and delivery of services can be improved to increase the quality of patient care, ensure better patient outcomes, and contribute to improved population health.

The programme is being managed by a National Coordinating Centre (NCCSDO) at the London School of Hygiene and Tropical Medicine. Dr Maureen Dalziel is the programme Director. The Centre was set up in April 1999 and the programme formally launched in March 2000 by Lord

Hunt, Parliamentary Under Secretary of State for Health. The Centre combines academic expertise in SDO research with programme management. It's staff have health service management, clinical, research and administrative backgrounds. It supports the programme director by:

- ◆ Providing a national focus for SDO R&D.
- ◆ By identifying and prioritising topics, commissioning research and project management.
- ◆ Linking with a wide range of stakeholders including those that make use of, deliver and determine health services as well as those who manage and conduct research.

The Centre aims to create a body of knowledge on service delivery and organisation research by drawing on relevant

Themes for SDO

- Organising health services around the needs of the patient
- User involvement
- Continuity of care
- Co-ordination/integration across organisations
- Inter-professional working
- Workforce issues
- Relationship between organisational form, function and outcomes
- Implications of the communication revolution
- The use of resources, such as ways of disinvesting in services and managing demand
- Implementation of major national policy initiatives such as the national service frameworks.

knowledge and by building networks from within and outside the health service.

Research themes

In autumn 1999 the NCCSDO organised a national 'listening exercise' to help them understand the issues which are most important to those delivering and organising services and to those receiving them. Over 350 people were involved. Ten themes that will inform the SDO programme of work were identified (Table).

In the meantime three pieces of work are in hand.

First, a scoping study to identify further areas of research on the continuity of care.

Second, a review of models of change management: the findings from this will be published in autumn 2000 in various forms including a user-friendly manual for managers.

Third, a synthesis of research methods relevant to SDO issues.

For further information contact

Kate Thomas
Co-ordinator
NCCSDO
London School of Hygiene and Tropical Medicine
99 Gower Street
London WC1E 6AZ

Telephone 020 7612 7980
Fax 020 7612 7979
Email sdo@lshtm.ac.uk

Copies of the SDO publication are available.
National Listening Exercise: Report of the Findings and Using Research to Improve Health Care Services

IMPROVING ORAL POSTOPERATIVE ANALGESIA

Promoting an evidence-based approach at Stoke Mandeville Hospital, Aylesbury

Why was the initiative launched?

Successive initiatives in the 1990s at Stoke Mandeville Hospital had made progress in using new analgesic techniques like epidural, spinal, patient and nurse controlled analgesia. But management of subsequent 'step-down' prescribing of oral analgesics was not keeping pace. Patients' post-operative care was not the best because of the inadequacy of the oral component. Prescribing at this stage was unstructured, with a wide range of oral analgesics in routine use, without any evidence base. Expenditure on oral analgesia was rising rapidly.

There was a growing feeling that something needed to be done. An opportunity for action came following the publication in 1997 of a review of the effectiveness of prescribing for pain relief which offered the basis for implementing an evidence-based approach (HJ McQuay, RA Moore, D Justins. Acute pain. British Medical Journal 1997 314: 1531-35).

What was done?

A team of people (Trevor Jenkins, Principal Pharmacist and Elaine Taylor, Nurse Specialist, supported by Dr John Sale, Consultant Anaesthetist) took the initiative in the early months of 1998 to find ways to tackle the situation. Their initial analysis suggested three issues needed attention:

- ◆ It was not clear who had responsibility for the education of prescribers, nurses or pharmacists.
- ◆ New junior doctors were asking nurses 'which oral analgesic is usually prescribed' rather than thinking about what was best for patients.
- ◆ There were blurred inter-professional relationships at ward level between prescribers, nurses and pharmacists.

Creating a framework for action

The review provided a basis for recommendations for effective oral postoperative analgesics and a framework for care. Findings from local audit studies illustrated the diversity local prescribing practice: 13 different medicines were prescribed to 45 patients.

The framework was designed to be evidence-based (on analgesic efficacy), to focus choice on appropriate medicine, route, and mode of delivery and be simple and safe to use. It aimed at enhancing multi-professional working. The recommended medicines included diclofenac and paracetamol with or without codeine. Diclofenac 50 mg was recommended to minimise the number of changes required, and because of the range of preparations available.

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BOTTOM LINES FOR SUCCESS

Building experience from ImpAct case studies

What was learned by those involved? and What are your 'tips for success' for others wanting to tackle a similar initiative? These are two questions we ask when we are preparing *ImpAct* case studies. We tell people we expect them to be honest about what went right and what went wrong. We don't want a glossy picture that skates over the difficulties.

It often surprises us that local project teams have not systematically sat down and talked about these questions. It should be an essential discussion for all project teams: we all have things to learn. Experience suggests that setting aside time in the middle of a team meeting for 'reflection and learning' is the best solution. All members are then likely to be present, catching those who turn up late and those who 'have' to leave early!

After we have completed each case study we step back and identify *ImpAct* bottom lines, what seems to us to have been the key action/s to assure success. In the seven issues of *ImpAct* so far we have included 27 case studies. *ImpAct* bottom lines fit into three groups: those about the impact of *patients* on the work, those about the *people* involved and those about the *supporting systems and process*. Here our aim is to draw lessons from the case studies that have general application.

ImpAct bottom lines

It has surprised us that there are only three *ImpAct* bottom lines about *patient* involvement (Box 1). Perhaps '*working with patients can be a learning process*' says it all. Despite several years of effort devoted to this issue we still seem to have a lot to learn. People now know that they should involve patients, both in their own treatment and in development work, but few know how to do it successfully. We'll keep this in mind as we prepare case studies.

Ways to encourage the innovation of and build on the enthusiasm of *people* working in the NHS are common features of the case studies (Box 2). We've noted four main themes. *First*, ensure that people have time to get involved in development work, though in ways that do not prejudice their clinical responsibilities. Space and time are es-

Box 1. ImpAct bottom lines: About working with patients

- Working with patients can be a learning process for clinical staff and patients.
- Work with volunteers from the community to keep developments going but be sure that the community supports the endeavor.
- Collaboration between primary and secondary care can impact significantly on little things that make a difference, like the number of patients who don't turn up for appointments.

Box 2. ImpAct bottom lines: About the people involved.

Time

- Time spent telling staff affected by initiatives what is going on is never wasted.
- Make sure that people can get involved: change rosters so that they can attend training sessions.
- Make adopting change easy for clinicians: find ways to facilitate change, which do not unduly add pressure to clinical commitments.

Skills

- Practical training makes things happen.
- Just because people use the language of IT don't assume that they understand it.
- Find ways to value and make the most of the skills and experiences of staff locally before bringing in 'outsiders'.
- Exploring ways to use therapy assistants offers practical and economic opportunities to improve the quality of care to patients.
- Don't rest on the status quo: encourage innovative ideas and the potential of new roles as ways to improve service quality.

Teams

- Devote effort and time to training and team building.
- Achieving change can be hard work: share out the tasks, but make sure people know what is expected of them, and when.
- Do not underestimate the positive impact development work can have on staff morale.
- Effective inter-disciplinary work requires understanding and communications between team members. It must be worked at; it will not happen by magic.

Leadership

- Active, senior, leadership is important when tasks require co-ordination across large (and small) organisations.
- Avoid the careless use of meaningless (job) titles.

essential to allow people to adopt new ideas and approaches. *Second*, find ways to ensure that the existing skills are used to the best effect. *Third*, initiatives to improve team working are time well spent. *Fourth*, leadership to harness the skills and release the energy of staff is essential. We understand that the Department of Health is making progress in a new series of initiatives to improve management and leadership in the NHS. We'll report on progress in a future issue of *ImpAct*.

The case studies remind us yet again that effective local development work needs good people and good systems. We've identified four themes about *systems and processes* (Box 3). *First*, value simplicity and don't believe that com-

**Box 3. ImpAct bottom lines:
About local systems and processes.**

Simplicity

- Efficiency and effectiveness thrive on doing simple things well.
- Small initiatives can lead to big savings.
- Take time out to learn about developments elsewhere when developing new services: don't re-invent the wheel!
- Use pilot studies to verify potential benefits from change and remember that success breeds success.
- Don't believe that complex solutions are bound to be the best: simple approaches can be effective.
- Look for simple practical ways to use IT: don't be tempted by over elaborate solutions.

Techniques

- Using a recognised development model can ensure that effort and resources are used to the best effect.
- Tackling those parts of a process that dictate the pace overall may be the best way to achieve rapid change.
- Don't be afraid to try new ideas, but have the courage to stop if they don't work.
- Look for practical ways to improve and build on existing systems: don't believe that you have to start afresh on everything.
- Be patient and persistent: creating effective services for small groups takes time.
- There are no quick answers.
- Persistence is required if you want to overcome long-standing problems.

Information

- Find novel ways of tackling problems: set standards but allow practices to find their own ways to deliver those standards.
- Make sure that you know what needs to change before making detailed plans: don't rely on anecdotes. Make sensible use of questionnaires
- Investment in time may be worthwhile if it produces a uniform and efficient way of doing things rather than major change.
- Solutions have to be tailored to the particular problem. Solutions may be different but the process of solving them is the same.

Communication

- Time devoted to communications and ensuring that staff affected by initiatives 'know what is going on' is never wasted.
- Services that are outward looking and that care about how others perceive them are more likely to succeed. Influence is born of good relationships, not internal structures and systems.
- Make new services work and be successful, so good that ways have to be found to resolve any funding issues.

Finally, remember

- Solutions do not last forever - be ready to change systems when they start to show their age.

plex solutions are always needed. *Second*, build on proven management techniques as a framework for the work, such as EFQM, ToC and CQI. *Third*, recognise the importance of information and IT systems. These ensure a focus on what needs to change and allow progress to be measured. But it is easy to forget in the hype about the 'dotcom' world that many people in the NHS may not be at first base in understanding and using information technology. *Fourth*, make sure that local channels of communications are open and used to keep people in touch with progress: ignorance breeds doubt.

Taken together the *ImpAct* bottom lines suggests that good practice thrives where five key activities are integrated, ie:

- ◆ *Information*: identifying the need for change, to develop new standards and monitor progress.
- ◆ *Communications*: keeping people in touch.
- ◆ *Training*: ensuring people and teams have space and time to develop and learn new skills, ideas and approaches
- ◆ *Involving patients*: ensuring that appropriate arrangements are in place.
- ◆ *Management*: ensuring that planned change happens

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To promote discussions the team arranged for their analysis and recommendations to be discussed with medical staff at a meeting in Autumn 1998 as part of the Trust's clinical audit programme. The session encouraged debate about diversity, about personal preferences, about the research evidence, and about responsibilities and training. After rigorous discussion, all anaesthetic and surgical consultants endorsed the framework: junior doctors welcomed the evidence-based approach. The meeting allowed progress to be made in planning how the changes would be implemented from 1st January 1999.

Training

A training initiative took the message to clinical staff: they did not believe that it would be practical to reach all those involved through educational lectures. The nurse specialist arranged visits to each ward to explain the new approach to nursing staff. Care was taken to ensure that these visits were convenient and that all nurses on the wards were involved. These ward-based workshops covered the new approach and how to advise medical staff on best choice and prescribing when asked, 'what does this hospital usually prescribe for pain relief?'. The Principal Pharmacist arranged similar sessions for clinical pharmacists in the hospital. Again care was taken with timing and location to ensure that all pharmacists were involved.

A fact sheet was prepared to link the evidence-base to the recommendations and provide a flow chart for managing prescribing. Posters of the framework, with a prescribing example, were put up on surgical wards to remind staff about the new approach. A clinical guideline was issued to all professions involved with postoperative care of patients (shown in Internet story).

The team has also involved patients in their work, by creating information leaflets for patients undergoing day surgery and adolescent in-patients.

Did it make a difference?

Two indicators show that the quality of prescribing has increased significantly at no extra cost, ie:

- ◆ increased use of recommended oral analgesics, especially paracetamol
- ◆ the apparent cost per surgical in-patient finished consultant episode (FCE) remained broadly the same or even fell

Anecdotally, nursing staff say that patients' postoperative pain is better controlled and patients' co-operation has improved. Pain control is being pre-empted and dealt with more effectively without any wait for alternative analgesia. The initiative has had the added benefit of promoting the roles of the Acute Pain Nurse Service and Pharmacists within the hospital. It has encouraged clinical staff to seek advice to improve patients' pain control.

The *training initiatives* have been particularly successful.

Nurses now feel empowered and more confident they have an evidence base on which to advise junior doctors. The flow chart has bred new confidence in all staff when advising patients, relatives and colleagues on effective pain control. The six-monthly arrival of new junior medical staff provides a regular opportunity to reinforce the messages about the local approach. Within induction programmes the Acute Pain Service explain the use of the flowchart.

This work is a good example of collaboration between specialities working for the benefit of the patient:

- ◆ Patients are receiving the most effective analgesics
- ◆ Step-down from PCA and epidural is efficient and effective
- ◆ Nurses and midwives have a simple, safe tool to manage postoperative pain
- ◆ Junior doctors learn evidence-based practice.

Tips for success

- √ Use a multi-professional approach (ie engage all those involved). An approach through a single professional group is likely to fail.
- √ Create easy to read, single-sheet frameworks but make sure detail is available in a written clinical guideline.
- √ Make the framework easily visible in clinical areas.
- √ Educate junior doctors as soon as possible after induction.
- √ Question *what is the best choice* rather than *what is usually prescribed*.

To find out more contact

About the framework:

Trevor Jenkins
Pharmaceutical Adviser
Milton Keynes PCG
The Hospital Campus
Milton Keynes MK6 5NG

About the effects:

Elaine Taylor
Acute Pain CNS
Stoke Mandeville Hospital
Aylesbury
HP21 8AL

Tel 01908 243873

01296 316552

Fax 01908 243517

01296 315264

Email Trevor.Jenkins@MKG-TR.anglox.nhs.uk

The following material is available

Fact Sheet

The framework/flow chart (Internet)

Adolescent in-patient information booklet

Day surgery discharge information sheet about analgesics

Cost comparison, before and after (Internet)

ImpAct bottom line

⇒ Educate everybody involved. Take education to them and don't expect them to come to you.

BREAKING BAD NEWS TO PATIENTS

Using patients' views to improve neurosciences at King's Healthcare NHS Trust in south London

Why was the initiative launched?

A new neuroscience service was created at King's Healthcare in 1995. Services previously based at the Brook and Maudsley Hospitals were brought together on the King's site. The management team wanted to link the creation of the new service with multi-disciplinary team working and improved service to patients. The team sought help from the Trust's Transforming Healthcare Delivery team.

What was done?

In the early 1990s King's Healthcare was one of two Trusts in England funded to explore the relevance of process re-engineering techniques to the NHS (see *ImpAct* January 2000, v 2 issue 1). A Transforming Healthcare Delivery team grew out of that work. A range of services has been tackled by the team, including cardiac disease and asthma. The teams' approach focuses on care routes to redesign health service delivery from the patients' perspective (Figure on website).

Creating a Care Route

The first task was to create an overview of the service from the patients' perspective. It was decided to concentrate on patients with brain tumours as a catalyst for change: they use all aspects of the neurosciences service. It is a regional service, and travel for staff to clinics at other sites, and patients, is inevitable. Patients are happy to travel to receive a high quality service. But that travel creates the challenge of ensuring that the service is organised and efficient. Staff drew up and validated a process map showing patients' journeys through the service. The chart covered 100 square feet and demonstrated the complexity of the system. The work was managed to ensure that all staff were aware of the project and how they could contribute.

The second task was to interview randomly selected patients who had recently used the service. Interviews were deliberately unstructured to allow the patients to speak freely about all aspects of their care. All the interviews were transcribed. Patients' comments could then be stuck on to the process map: a blue bubble for positive comments and

red bubble for problem areas. After this analysis was completed it was obvious from the red bubbles that two areas needed attention: outpatients, and communications with patients, or how bad news was given.

Two multi-disciplinary teams were set up which included staff from St Thomas' where patients receive radiotherapy. Members of the Transforming Healthcare Delivery team facilitated the project teams: they met monthly for six months to analyse problems and develop solutions.

Improving outpatient experiences

Two problems needed attention. Patients expressed concern about delays and an apparent lack of organisation of clinics. Delays happened because patients were seen by a large number of clinicians, and consequently were often intimidated by the process. The team recommended a new process for allocating patients to the most appropriate clinician, the person best suited to the patients' needs on the day.

Scans were often unavailable because of the time taken to get them back to the Department from King's (requiring transfer across the hospital site) or other hospitals. Moreover they were stored in fourteen different places on site. Finding them at the right time was a real problem. A number of changes speeded up the process, with a computerised tracking system and a central store.

Patient communication: breaking bad news

Patient concerns ranged from the way that telephone messages were passed to the way that staff handled giving bad news about a patient's diagnosis, which could range from a couple of breezy sentences about death or disability to a gory account of every possible risk. The team looked at written material (there was none) and the way that verbal communication was handled. Some quick improvements were achieved by creating a new information package.

The main challenge was to find ways to improve the process for breaking bad news. The team's investigation identified a number of problems (Box). A structured approach was needed which took account of:

- ◆ the time when news can be broken; when test results were available
- ◆ the availability of an appropriate person; suitably qualified to engage in a two way dialogue
- ◆ what sort of information was required
- ◆ when patients have the support their families.

Nurses hold the key to the new process: a nurse co-ordinates a meeting to pass on the results of the diagnosis. This enables appropriate staff to be available, allows the patient to ensure friends and relatives are present, and ensures that the discussion takes place in a separate room not in front of other patients. A training programme was devised to ensure that all staff understand and can contribute to the new approach. The programme includes a new session in their induction programme for junior doctors, workshops for nurses, therapists and radiographers, and for administrative and clerical staff as well.

Problems identified

Information was given:

- By inexperienced staff
- In an insensitive manner
- Without the relatives being present
- By an inappropriate person
- By staff who could not then answer questions
- After an unnecessary delay
- In a poor environment
- Without the opportunity for discussion

Table 1: making a difference

Indicator	Baseline	Target	March-00
Maximum wait in clinics (minutes)	145	30	15
Median wait in clinics (minutes)	33	20	5
Availability of scans, Kings (% available)	78	85	96
Availability of scans, other hospitals (% available)	57	75	75
Written material for patients	0	5 leaflets 1 poster 6 racks	11 leaflets 1 poster 6 racks
Training programmes for nurses	0	60% by 9/99 80% by 12/99	100%
Training workshops for A&C staff	0	3	3 in 1999
Patients perceptions (%) of adequacy of privacy	31	70	65
time given by staff	44	70	69
clarity of explanation	48	70	73

Has it made a difference?

When detailed work had been completed the team arranged a launch day. The board room walls were covered with all the work undertaken and the team members were available throughout the day to talk staff through the solutions.

The team identified a number of indicators which could be monitored to gauge whether targets had been achieved. Some of these data were gathered when the initial analysis was being undertaken. A range of techniques was used, including the use of routine data to the use of questionnaires to patients. The majority of the targets set have been met or surpassed. The key indicators are set out in Table 1.

The programme has also enabled the King's Transforming HealthCare team to further develop its methodology. The focus is now much more on the task of implementation where resistance is more likely to be met and where the hard work of previous phases can fall down.

Tips for success

- ✓ Using patients' views prevents disagreement about whether there is a problem and about whether it is important.
- ✓ Working through teams helps to keep a focus on realistic solutions owned by those involved.
- ✓ Remember that teams can lose enthusiasm in the middle of projects when problems have been identified but solutions are proving difficult to implement. It's not unusual.
- ✓ Encourage radical thinking in seeking solutions because people may have a natural propensity towards conservative solutions and want to take the easy route.
- ✓ Senior commitment can help create more confident teams and allow them to pursue more radical solutions.
- ✓ Achieving changes requires stamina: it's hard work. Make sure that the right level of support is available when solutions are being implemented.

For more information contact

Kate Grimes
Programme Leader: Transforming Healthcare Delivery
King's Healthcare NHS Trust
King's College Hospital
Denmark Hill London SE5 9RS

Telephone 020 7346 3188
Fax 020 7346 3721
E-mail Kate.Grimes@mail.kingshc.nhs.uk

The following material is available

New consent form
Documentation for results discussion
Written information for patients
View of staff who took part in the project

ImpAct bottom line

⇒ **Involving patients helps get commitment from staff and gives momentum for action.**

EDITORS

Michael Dunning Andrew Moore

Pain Relief Unit, The Churchill, Oxford OX3 7LJ

Editorial office: 01865 226132
Editorial fax: 01865 226978
Email: andrew.moore@pru.ox.ac.uk
michaeldunning@hotmail.com
Internet: www.ebandolier.com